

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

**HEPATITIS C, ACUTE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 60**

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U
 If yes, symptom onset date (mm/dd/yyyy): ___/___/___
 CHECK ALL THAT APPLY:

Fatigue/malaise/weakness..... Y N U
 Loss of appetite (anorexia)..... Y N U
 Weight loss with illness..... Y N U
 Nausea..... Y N U
 Vomiting..... Y N U
 Abdominal pain or cramps..... Y N U
 Joint pain..... Y N U
 Enlarged liver (hepatomegaly)..... Y N U
 Elevated liver enzymes..... Y N U
 (ALT>400 IU/L)
 If yes, specify level: _____
 Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia).... Y N U
 If yes, date of onset: (mm/dd/yyyy) _____
 Dark urine (bilirubinuria)..... Y N U
 If yes, date of onset: (mm/dd/yyyy) _____
 Other symptoms, signs, clinical findings, or complications consistent with this illness..... Y N U
 If yes:
 Specify: _____
 Tested for IgM anti-HAV?..... Y N U
 If yes, results:..... positive negative
 Tested for IgM anti-HBc?..... Y N U
 If yes, results:..... positive negative

PREDISPOSING CONDITIONS
 Any immunosuppressive conditions? Y N U
 Specify _____

REASON FOR TESTING
 Why was the patient tested for this condition? (Select all that apply)
 Symptoms of acute hepatitis
 Screening of asymptomatic person with reported risk factor(s)
 Elevated liver enzymes
 Blood/organ/tissue donor screening
 Follow-up for previous marker for viral hepatitis
 Blood/body fluid exposure
 Healthcare exposure
 Other, specify: _____
 Unknown

HOSPITALIZATION INFORMATION
 Was patient hospitalized for this illness >24 hours?..... Y N U
 Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) _____ - _____
 Admit date (mm/dd/yyyy): ___/___/___
 Discharge date (mm/dd/yyyy): ___/___/___

ISOLATION/QUARANTINE/CONTROL MEASURES
 Restrictions to movement or freedom of action?..... Y N
 Check all that apply:
 Work Sexual behavior
 Child care Blood and body fluid
 School Other, specify _____
 Date control measures issued: _____
 Date control measures ended: _____
 Was patient compliant with control measures?..... Y N
Did local health director or designee implement additional control measures?..... Y N
 If yes, specify: _____
Were written isolation orders issued?..... Y N
 If yes, where was the patient isolated? _____
 Date isolation started? _____
 Date isolation ended? _____
 Was the patient compliant with isolation?..... Y N

CLINICAL OUTCOMES
 Discharge/Final diagnosis: _____
 Survived?..... Y N U
 Died?..... Y N U
 Died from this illness?..... Y N U
 Date of death (mm/dd/yyyy): ___/___/___

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 None of the above

Notes:

HEALTH CARE FACILITY AND BLOOD & BODILY FLUID EXPOSURE RISKS

From 2 weeks to 6 months prior to onset of symptoms/illness did the patient have any of the following healthcare facility exposures?

Patient was hospitalized..... Y N U
 Patient was a resident of a long term care facility (e.g., nursing home, rest home, rehab)..... Y N U
 Patient underwent dialysis Y N U
 If yes:
 Facility Name _____
 City _____
 State _____ Country _____
 Patient had puncture or accidental stick with a needle or other object known to be or possibly contaminated with blood..... Y N U
 Received blood or blood products (transfusion)..... Y N U
 Date received (mm/dd/yyyy) _____
 Date unknown
 Facility or Provider name _____
 Address _____
 Contact name _____
 Received any IV infusions (other than blood/blood product transfusions) and/or injections in an outpatient setting..... Y N U
 Patient had dental work or oral surgery..... Y N U
 Other surgery (besides oral surgery), obstetrical or invasive procedure..... Y N U
 Was patient employed in a medical or dental field involving direct contact with human blood?..... Y N U
 Was frequency of direct blood contact
 Frequent (several times weekly)
 Infrequent
 Unknown
 Did the patient have other blood and/or body fluid exposure?..... Y N U
 Have non-healthcare related exposure to someone else's blood?..... Y N U
 Specify _____
 Was patient employed as a public safety worker (firefighter, law enforcement, or correctional officer) having direct contact with human blood?..... Y N U
 If yes, was frequency:
 Frequent (several times weekly)
 Infrequent
 Unknown

Notes:

BEHAVIORAL RISK AND CONGREGATE LIVING

During the 6 months prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)?..... Y N U
 Name of facility: _____
 Dates of contact: _____
Has the patient ever been incarcerated longer than 24 hours?..... Y N U
 Indicate all facilities that apply:
 Jail Juvenile
 Prison Unknown
Has the patient ever been incarcerated for longer than 6 months?..... Y N U
 Year of most recent incarceration of longer than 6 months: _____
 Date of most recent incarceration of longer than 6 months: _____
Has the patient ever received any tattoos?..... Y N U
 If yes, where was the tattoo performed?
 Commercial parlor/shop, specify name: _____
 Correctional facility
 Other, specify _____
 Unknown
Has the patient received any piercings (other than ears)?..... Y N U
 If yes, where was the piercing performed?
 Commercial parlor/shop, specify name: _____
 Correctional facility
 Other, specify _____
 Unknown
Has the patient ever used injection drugs not prescribed by a doctor?..... Y N U
Has the patient ever used NON-injection street drugs?..... Y N U
Has the patient had sexual contact with a known or suspected case of this disease?... Y N U
Has the patient ever been diagnosed with a sexually transmitted disease (STD)?..... Y N U
 Indicate year of last STD treatment: _____
During the 6 months prior to symptom onset, has the patient had sexual contact with a FEMALE?..... Y N U
 If yes, specify number of female partners _____
During the 6 months prior to symptom onset, has the patient had sexual contact with a MALE?..... Y N U
 If yes, specify number of male partners _____
In what setting was the patient most likely exposed?
 Restaurant Place of Worship
 Home Outdoors, including woods or wilderness
 Work Athletics
 Child Care Farm
 School Pool or spa
 University/College Pond, lake, river or other body of water
 Camp Hotel / motel
 Doctor's office/ Outpatient clinic Social gathering, other than listed above
 Hospital In-patient Travel conveyance (airplane, ship, etc.)
 Hospital Emergency Department International
 Laboratory Community
 Long-term care facility /Rest Home Other (specify) _____
 Military Unknown
 Prison/Jail/ Detention Center

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 Specify _____

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____
Were interviews conducted with others?..... Y N U
 Who was interviewed? _____
Were health care providers consulted?..... Y N U
 Who was consulted? _____
Medical records reviewed (including telephone review with provider/office staff)?..... Y N U
 Specify reason if medical records were not reviewed: _____

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
 Specify location:
 In NC
 City _____
 County _____
 Outside NC, but within US
 City _____
 State _____
 County _____
 Outside US
 City _____
 Country _____
 Unknown

Is the patient part of an outbreak of this disease?..... Y N

Notes:

Hepatitis C, Acute

2012 Case Definition

CSTE Position Statement Number: 11-ID-05

Clinical Description

An acute illness with a discrete onset of any sign or symptom* consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), and either a) jaundice, or b) elevated serum alanine aminotransferase (ALT) levels >400IU/L.

*A documented negative HCV antibody laboratory test result followed within 6 months by a positive test (as described in the laboratory criteria for diagnosis) result does not require an acute clinical presentation to meet the surveillance case definition.

Laboratory Criteria for Diagnosis

One or more of the following three criteria:

- Antibodies to hepatitis C virus (anti-HCV) screening-test-positive with a signal to cut-off ratio predictive of a true positive as determined for the particular assay as defined by CDC. (URL for the signal to cut-off ratios: <http://www.cdc.gov/hepatitis/HCV/LabTesting.htm>), OR
- Hepatitis C Virus Recombinant Immunoblot Assay (HCV RIBA) positive, OR
- Nucleic Acid Test (NAT) for HCV RNA positive (including qualitative, quantitative or genotype testing)

AND, if done meets the following two criteria:

- Absence of IgM antibody to hepatitis A virus (if done) (IgM anti-HAV), AND
- Absence of IgM antibody to hepatitis B core antigen (if done) (IgM anti-HBc)

Case Classification

Confirmed

A case that meets the clinical case definition, is laboratory confirmed, and is not known to have chronic hepatitis C.